Welcome To Our Office

Last Name	First Name	MI	Today's Date

Age	Date of Birth	Sex ☐ Male ☐ Female	Marital Status

Street Address	City	State	Zip Code

E-Mail Address

Name of Emergency Contact	Emergency Contact Telephone Number

Preferred Contact Method

Cell/Mobile Number _____ Carrier _____

Home Telephone Number _____

Work Telephone Number _____

Would you like appointment reminders via Text or E-Mail?

☐ Yes Text ☐ Yes E-Mail ☐ No Thanks

Whom do we thank for referring you to our office?

☐ Webpage/Internet ☐ Yellow Pages

☐ Referral from Family/Friend _____

☐ Referral from Doctor _____

☐ Other _____

To Which Doctor?

☐ Dr. Aaron Heitman ☐ Dr. Alex Heitman

Employer

Office Policy

Our office motto is *"to treat you as we would want to be treated ourselves"*. We are happy to have you as a patient whether you have insurance or not. If you do not have insurance we are able to offer you our Medicare fee rate. If you do have insurance we will accept insurance assignment only if your insurance company has been pre-authorized by the office staff. Otherwise, fees for services are expected to be paid in full at the time of service. We accept Cash, Checks, Debit Cards, MasterCard, Visa, American Express, and Discover. Notice: all delinquent accounts over 60 days will receive a $10.00 per month additional accounting fee.

Patient Initials _____

If you have **HEALTH INSURANCE** or your problem is a result of an **AUTO ACCIDENT or WORK-RELATED INJURY** please speak with the office staff prior to any consultation with the DOCTOR.

PATIENT CONDITION HISTORY FORM

What is the purpose of your visit? _____

_____

_____

Approximately how long have you had this condition? _____

Have you had similar problems in the past? ☐ **No** ☐ **Yes, When?** _____

What do you think caused this problem? _____

_____

_____

What activities aggravate your condition? _____

_____

What have you done to make it better? _____

_____

Does your pain radiate or extend to other areas? ☐ **No** ☐ **Yes, into my** _____

_____

Is this condition getting worse? ☐ **Yes** ☐ **Comes and goes** ☐ **Stays the same**

This condition limits my ability to: ☐ **Work** ☐ **Sleep** ☐ **Daily Activities?** _____

_____

What would you like to be able to do that your condition currently limits? _____

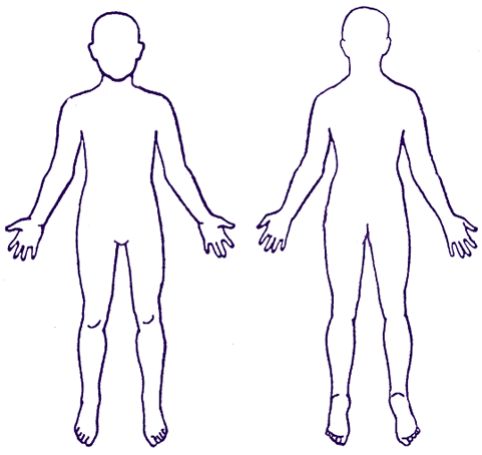
_____

Have you seen another Doctor for this condition? ☐ **No** ☐ **Yes**

Doctor's Name: _____ **Diagnosis:** _____

Treatment: _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW.



List past Surgical Operations with approximate dates:

List other complaints:

List Medications if any: Purpose?

Do you personally have any history of the following: (please check all that apply)

- ☐ Aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ HIV+
- ☐ Neck or Back Surgeries
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Tuberculosis

Have you ever seen a Chiropractor before? ☐ No ☐ Yes

If yes approximate date of last treatment

For Women Only: Are you pregnant? ☐ No ☐ Yes – Due Date

To help us better explain your chiropractic condition and how we may be able to benefit your needs, Please answer the following:

What are your goals for care?

- ☐ Symptomatic pain relief only
- ☐ Correction of the problem
- ☐ Wellness care

Consent to Chiropractic Services

I authorize the performance upon myself or upon my named child _____

The following procedures the Doctor deems necessary:

Chiropractic examination, spinal adjustments, intermittent traction, ice therapy, light therapy, ultrasound, muscle stimulation therapy, and/or x-rays if needed.

I understand the nature and purpose of the procedures, possible alternatives, and the risks involved will be explained to me by the Doctor before treatment occurs. I also understand that I, as a patient, am responsible to ask the Doctor any questions or concerns regarding treatment procedures in this office.

I understand that my health information will be kept private and that I do have rights to that information upon request. An informational booklet is available at this office for review on how we use your information.

_____ _____

Patient or Authorized Signature Date